

## **Focus Ahead for Better Health**

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McKesson Health Solutions helps payers and providers simplify and automate reimbursement to engage each other and consumers in the transition to value-based care.

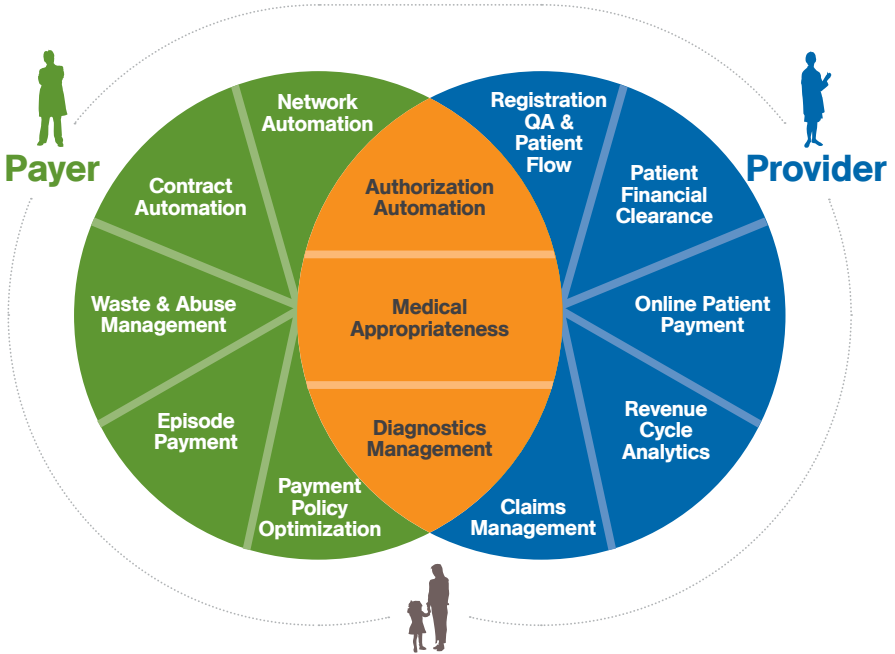


# **McKesson Health Solutions: Simplify, Automate & Engage**

Payers and providers face rapid, system-wide change as the health care industry moves from volume- to value-based reimbursement (VBR) and the consumer becomes more engaged. Every health care organization must support a complex, ever-changing mix of fee-for-service (FFS) and VBR models, all while learning to engage each other and consumers differently than ever before.

In this disruptive era, the right technology is crucial to maintaining a long-term competitive advantage. That's why McKesson Health Solutions works closely with our payer and provider customers to help address long-term efficiency by automating and transforming complex financial and clinical processes to help simplify reimbursement. And it's why we continue to invest in our technology to support VBR transformation. Simplifying the reimbursement process is fundamental to helping our clients support transparency, engage their audiences differently, and continue to drive down costs and improve quality.

# Simplifying, Automating & Transforming Health Care Reimbursement



## Member/Patient

Our portfolio enables our clients to be more transparent with patients

**NETWORK & FINANCIAL  
MANAGEMENT**

**DECISION  
MANAGEMENT**

**REVENUE CYCLE  
MANAGEMENT**

# We Are Focused On Your Key Challenges

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In today's dynamic world of health care, a more collaborative, interconnected system is emerging—and the gap between business health and patient health is narrowing.

As part of McKesson, America's largest and longest-serving health care company, we bring a unique 360° perspective across the industry to help payers and providers transition to value-based care by managing the payment changes that are involved.

# Value-Based Reimbursement



“Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely, and results in healthier people. Today’s announcement [to tie 50% of payments to quality or value by 2018] is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely.”

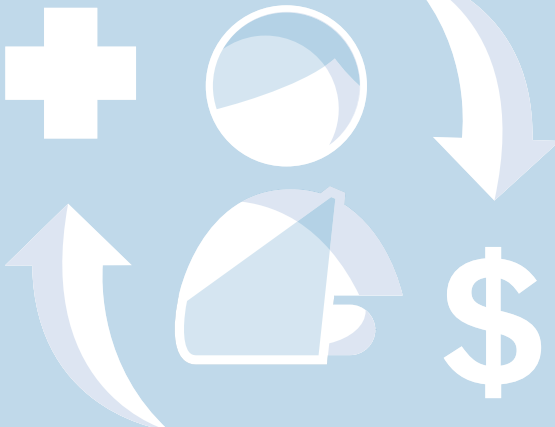
—U.S. Health & Human Services Secretary Sylvia Burwell, Jan. 26, 2015<sup>1</sup>

Regulatory change, market pressures, and the availability of new technologies are accelerating the adoption of VBR models. McKesson Health Solutions helps payers and providers navigate the transition from FFS to VBR by embracing, adapting, and scaling a complex mix of evolving payment models.

**We help payers** transform network management and re-engineer FFS processes to meet evolving VBR models and needs. We automate, transform, and simplify complex payment scenarios, providing unparalleled consistency, accuracy, and speed that make it possible to implement and scale more efficient and effective models.

**We help providers** make appropriateness of care decisions that are in line with clinical evidence and value as well as streamline the revenue cycle management process to ensure that claims are submitted cleanly in order to avoid the increase in denials that can happen with increased payment model complexity.

**We help payers and providers by** enabling them to connect and automate decisions about patient eligibility and benefits, medical necessity, and payment processes.



## Value-Based Reimbursement: Industry Trends

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**90%**  
of Payers



**81%**  
of Providers

Are Already Using Some Mix of Value-Based Reimbursement Combined with Fee-for-Service<sup>2</sup>

In January 2015, the U.S. Department of Health & Human Services Announced an Initiative to Make

### Alternative Payment

the Standard for 30% of Medicare Reimbursement by 2016 & 50% by 2018<sup>4</sup>

**45%** of Providers Are Now Part of an ACO and **59%** of Those Not in an ACO Anticipate Joining One by 2020<sup>5</sup>

**2/3**

Payers and Providers Anticipate Two-Thirds of Payment will be Based on Complex Reimbursement Models with Value Measures by 2020<sup>3</sup>

46% of Payers and 23% of Providers Say Technology to Implement and Scale VBR Models is

**“Urgently Needed”<sup>6</sup>**

## Value-Based Reimbursement: Payer Trends

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**20**

Major Health Systems and Payers Pledged to Convert 75% of their Business to

**Value-Based Arrangements**

by 2020<sup>7</sup>

**1/2**

Of Blue Cross and Blue Shield of Massachusetts' Commercial Business is Under Alternative Contracts That Use 64 Quality Measures to Adjust Financial Incentives for Providers Under Global, Population-Based Budgets<sup>8</sup>

Aetna Ties **28%** of Payments to Doctors and Hospitals to Value-Based Contracts and Has a Target of **50%** by 2018<sup>9</sup>

# Operational Efficiency & Cost Management



"Of the \$2.7 trillion the country spends annually on health care, \$400 billion goes to claims processing, payments, billing, revenue cycle management, and bad debt—in part because half of all payer-provider transactions involve outdated manual methods, such as phone calls and mailings."

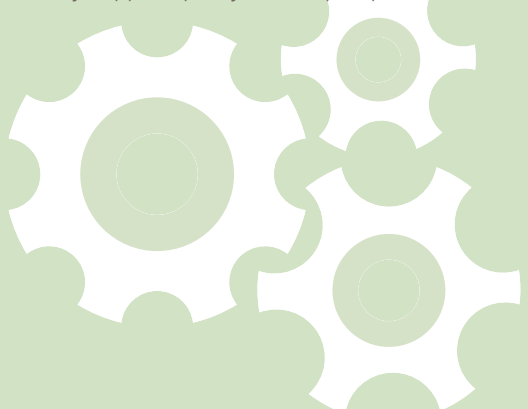
—McKinsey<sup>10</sup>

Value-based reimbursement promises to reduce costs and improve care quality in the future. But payers and providers need to cut costs now, without adversely affecting care, to strengthen their financial health in a fast-changing and highly competitive market. McKesson Health Solutions simplifies, automates, and connects health care processes and workflows, reducing costs, eliminating waste, and supporting financial health system-wide.

**We help payers** reduce administrative costs by streamlining complex payment and network management processes, and reduce medical costs by automating complex decisions and facilitating consistent use of the right evidence-based medical and payment policies.

**We help providers** lower administrative costs by automating utilization management and revenue cycle management processes, and support cost management by improving revenue capture with end-to-end revenue cycle management that reduces denials and boosts patient collection.

**We help payers and providers by** creating more collaborative workflows to speed consensus around evidence-based appropriateness of care decisions; quickly determine coverage status; and keep in sync with complex, evolving coverage, management, and reform policies by automating the application of clinical criteria to efficiently support quality and help improve outcomes.



## Cost Management: Industry Trends

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### **Providers Spend \$31 Billion Annually**

Interacting with Payers on Prior Authorization Requirements, Pharmaceutical Formularies, Claims, Credentialing, Contracting, and Quality Data<sup>11</sup>

**\$0.15**

Of Every U.S. Health Care Dollar Goes Toward Revenue Cycle Inefficiencies<sup>12</sup>

The Average Provider Spends

**20 Hours  
Per Week**

On Prior Authorizations<sup>13</sup>

### **Denial Rates Have Worsened**

Across All Quartiles Since 2011, With the Median Being 9% as a Percentage of A/R In 2013<sup>14</sup>

**\$150 Billion Wasted**

By Payers and Providers Annually In Administrative Inefficiencies<sup>15</sup>



## Cost Management: Customer Results

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By Using InterQual®  
A California Provider

### **Decreased Medical Costs**

from Nearly  
\$1 Billion to  
\$300 Million  
in 4 Years<sup>16</sup>

Palmetto GBA Realized  
**\$5 Million in  
Monthly Savings,**

Using McKesson  
Diagnostics Exchange™<sup>17</sup>

Payers Using ClaimsXten™

### **Achieved 28:1 ROI**

Through Medical Cost Savings  
and Saved 30% on  
Administrative Costs<sup>18</sup>

McKesson Provider  
Manager™ Can

### **Reduce The Cost**

to Payers of  
Administering  
Provider Relationships  
by 10%-25%<sup>19</sup>

Iowa Medicaid Enterprise Projected Saving **\$2.4 Million** in Medical  
& Administrative Costs in First Year, Using McKesson Clear Coverage™<sup>20</sup>

Good Samaritan Staff  
Reduced the Time Spent  
Pulling Biller  
Productivity Data from  
**2-3 Hours to  
5-10 Minutes**  
with Relay Assurance™<sup>21</sup>

Health First  
**Added a 4th Hospital**  
to its Network Without  
Adding Additional  
Financial Services  
Staff by Using  
RelayClearance™<sup>22</sup>

**↓ 20%**  
Silverton Hospital Used  
RelayAnalytics Pulse™  
to Lower Gross  
Unbilled A/R Days<sup>23</sup>

# Consumer Engagement



40% of consumers now say health care costs strain their budget.<sup>24</sup> It's easy to see why. They now pay almost 25% of medical bills and 37% of cost-sharing for employee benefit premiums. Out-of-pocket expenses at the point of care are 18%, with ER copays up 50% and specialty pharma copays up 94% since 2009. The deductibles now average between \$1000 and \$2000.<sup>25</sup>

—The American Medical Association, PwC Touchstone Survey, Towers Watson/National Business Group on Health Employer Survey

The Affordable Care Act and other regulatory and consumer technology changes have spawned a growing individual market where the role of the patient is evolving from a passive to proactive consumer. As of 2015, over 16.4 million people have gained health insurance since the ACA became law.<sup>26</sup> Many of these policies have high deductibles, which shift more of the financial and decision-making responsibilities to the patient.

Payers and providers must evolve their services and align their business processes to remain relevant and prosper. They need to engage patients transparently with timely, accurate information that supports making informed health care and financial decisions. And they need to make it easy for patients to connect with their financial information and payment services anywhere, anytime.

As the number of covered lives increases, payers and providers must be able to help consumers answer these three questions with confidence:

- 1 Is this the right care?**
- 2 Where can I get this care?**
- 3 How much will it cost?**



**We help payers** rapidly design and deploy provider networks that address new population risk profiles and appeal to discerning consumers, and provide their consumers with the information they need to make the right provider selection. We also enable the claims simulation necessary for price transparency.

**We help providers** create productive payment interactions with patients throughout the care cycle and engage with patients about how care choices impact financial obligations.

**We help payers and providers** speed preauthorizations through intelligent automation, and ensure that the care being provided is appropriate, based on the medical evidence.

## Consumer Engagement: Industry Trends

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**16.4 Million**

People Gained Health Insurance Coverage Under the Affordable Care Act<sup>27</sup>

**40%**

Of Consumers Now Say Health Care Costs Are Straining Their Budgets<sup>28</sup>

In 7 Months, **135 Bills** Were Introduced in State Legislatures Looking at Various Aspects of Price Transparency<sup>29</sup>

Patients Now Pay Almost

**25% of Medical Bills**  
**37% of Cost-Sharing**

for Employee Benefit Premiums<sup>30</sup>

Roughly Half of the Products Sold on Exchanges in 2014 were

**Narrow-Network Plans**<sup>31</sup>

**29 States**

Have Laws Requiring Price Transparency for Consumers<sup>32</sup>

**8 States**

Have Strong Transparency Requirements Deemed "Acceptable" by Consumer Groups<sup>33</sup>

CA Regulators Found

**Errors In Provider Directories**

Two Health Plans Listed 12.5% and 9% of Physicians in Their Directories as "In Network" Incorrectly<sup>34</sup>

## Consumer Engagement: Customer Results

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Using RelayAccount™ Allowed Gwinnett Medical Center to  
**Boost Online Patient Payments 40%**, Achieve a  
**\$1 Million Year-Over-Year Increase** in Insurance Self-Payments,  
and Significantly Reduce Call Center Volume<sup>35</sup>

Nearly 60% of Patients Ranked  
RelayHealth Financial Customer  
St. Luke's Health System  
**High on Patient Satisfaction**  
for its Explanation of Financial  
Obligations & Insurance Matters,  
Placing the Provider in the  
81<sup>st</sup> Percentile<sup>36</sup>

The Bellevue Hospital Used  
RelayHealth Financial's  
Ahi Lobby™ to Achieve a  
**55% Decrease in  
Patient Wait Times**  
for Visits and Treatments<sup>37</sup>

# Enhancing Care Quality & Value



“The bad news is that an estimated \$700 billion is wasted annually. That’s one-third of the nation’s health care bill. The good news is that by attacking waste, health care costs can be reduced without adversely affecting the quality of care or access to care. [We need] to identify areas in the health care system that can generate game-changing savings.”

—Robert Kelley, Vice President of Healthcare Analytics at Thomson Reuters<sup>38</sup>

In a increasingly value-based world, McKesson’s InterQual Criteria provide a common clinical language that aligns payers and providers in decisions about appropriateness of care to optimize utilization, reduce administrative costs, support better outcomes, and enhance the patient experience. And InterQual Criteria products make it easy to automate the application of evidence-based standards to improve consistency and simplify care management.

**We help payers** promote better outcomes by ensuring recommended care is appropriate based on the latest medical evidence, and that the claim is paid correctly based on the medical and payment policies in place.

**We help providers** deliver appropriate care with evidence-based clinical decision support criteria, and streamline the registration process by determining whether an authorization is required and on file with the payer.

**We help payers and providers by** deploying common evidence-based clinical criteria that align payers and providers in decisions about appropriateness of care to optimize utilization, reduce administrative costs, support better outcomes, and enhance the patient experience.



## Enhancing Care Quality & Value: Industry Trends

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Despite Spending  
**\$2.7 Trillion a Year  
on Health Care,**  
the U.S. Lags Behind the  
Developed World in Outcomes,  
Giving Little Value for the Money Spent<sup>39</sup>

Americans are Subject  
to Poor Quality  
Health Care:  
**Only 55% of  
Recommended  
Care Was  
Received**<sup>40</sup>

**\$250 Billion  
– \$325 Billion**  
is Billed Annually for  
Unnecessary Health Care  
(Overutilization, Overuse,  
Overtreatment)<sup>41</sup>

Readmissions Result in  
**\$41.3 Billion in  
Hospital Costs**  
Annually, of Which Cost for  
Medicare Patients Alone  
is \$24 Billion<sup>42</sup>

## Enhancing Care Quality & Value: Customer Results

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Length of Stay Was **8% Shorter** at Hospitals  
That Have InterQual Criteria for All Patient Types<sup>43</sup>

A Large Payer  
**Improved** Adult Med/Surg  
**Length of Stay by 10%**  
and **Sub-Acute**  
**Length of Stay by 45%,**  
in 18 Months with InterQual<sup>44</sup>

Achieving  
**\$21 Million  
Savings**  
With InterQual, the California State  
Department of Corrections &  
Rehabilitation Reduced Referrals  
from 25,000 per Month to 4,000<sup>45</sup>

# Product Catalog

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# Network & Financial Management Products: For Payers

By automating and integrating network and payment decisions, including, network design, contracting, and reimbursement, McKesson's Network and Financial Management solutions can help payers manage costs, implement new value-based reimbursement models, enhance payment accuracy, and reduce administrative costs. We help you build a solid technical foundation for the future so you can respond to a dynamic health care environment today.

## **ClaimsXten™**

ClaimsXten is a clinical payment and reimbursement policy management solution that includes advanced rules and clinically sound edits to drive medical and administrative savings which can help enable payment innovation. It integrates with payers' claims processing systems to help ensure adherence to coverage, reimbursement and benefit policies, as well as industry-standard coding practices. ClaimsXten is integrated with the McKesson Reimbursement Manager™ pricer and the McKesson Episode Management™ bundled payment engine.

## **InvestiClaim®**

InvestiClaim is a modular, enterprise level fraud, waste, and abuse management solution that combines the intelligent, proprietary claim rules engine and technology of the McKesson Total Payment platform with predictive help to identify both suspected and unknown billing aberrancies. The partnership of prepay clinical editing rules and pre- and post-pay neural analytics helps you avoid a higher volume of wasteful and abusive claims up front and makes fraud recovery efforts more efficient on the back end.

## **McKesson Contract Manager™**

McKesson Contract Manager is a health plan-specific contracting solution that streamlines the entire contracting process, enabling health plans to meet the needs of rapid healthcare system transformation and changing regulations. With a central repository for provider contracts, flexible contracting workflows, and a standard contract template library, McKesson Contract Manager helps eliminate configuration and payment errors, while enabling users to improve contract compliance. When integrated with McKesson Provider Manager™, it helps align networks and products with optimized provider contracts.



## **McKesson Episode Management™**

McKesson Episode Management supports health plans in developing and running full-scale bundled payment programs with either a retrospective or prospective rules-based approach within current claims workflows. From automating episode definitions and initiations through episode bundling and payment, this solution allows organizations to take advantage of 22 standard episodes covering procedural, acute, chronic, and other evidence-informed case rates, or tailor bundles.

## **McKesson Payer Connectivity Services™**

McKesson Payer Connectivity Services is a payer-facing, HIPAA-compliant EDI gateway solution that lets payers consolidate and manage inbound and outbound transaction streams at a single connection point. This flexible and scalable SaaS platform provides an end-to-end connectivity solution that enhances claims workflow.

## **McKesson Provider Manager™**

McKesson Provider Manager is the first and only enterprise provider platform proven capable of engaging providers differently to efficiently deploy targeted networks to your members. Provider Manager helps store, represent and manage the rich complexities in provider information and relationships, giving plans the agility to support new products, care models and reimbursement designs. With standardized and orchestrated workflows, Provider Manager helps you improve the accuracy and efficiency of your network operations, helping you drive health plan care delivery and reimbursement initiatives while decreasing costs and improving provider and member satisfaction.

## **McKesson Reimbursement Manager™**

McKesson Reimbursement Manager is an advanced pricing and reimbursement design tool that enables health plans to create, centralize, and optimize all provider reimbursement arrangements. It simplifies provider reimbursement into a single automated process that calculates the appropriate allowed amount during claims adjudication by applying the correct medical, payment, and reimbursement policies that can be contract specific or health plan standard policies.

# Decision Management Products: For Payers & Providers

The foundation of the Decision Management family is our market-leading clinical resource, InterQual®, which helps payers and providers ensure the safest, most appropriate care by enabling the consistent and optimal application of clinical evidence. The Decision Management technology solutions also help to reduce administrative costs through streamlined medical reviews and automated authorizations.

## InterQual® Criteria

This evidence-based clinical decision support portfolio improves decision making by providing a common clinical language to align payers and providers in care management decisions at all points of care. The portfolio includes four product suites:

- **InterQual Level of Care Criteria:** Assess the optimal care level based on severity of illness, comorbidities and complications, and the intensity of services being delivered. Covers more than 95% of admission reasons to any level of care.
- **InterQual Care Planning Criteria:** Identify when imaging studies, procedures, DME, MDx tests, specialty Rx and specialty referral consultations are appropriate.
- **InterQual Behavioral Health Criteria:** Manage the delivery of mental health and substance use care, including initial and concurrent level-of-care decisions.
- **InterQual Coordinated Care Content:** Manage the most complex of patients. Patented blended assessments address multiple conditions to generate a patient-specific care plan. The content is designed to help organizations meet NCQA case and disease program requirements. Easily integrates into most care management programs.

## InterQual® InterRater Reliability Suite

A web-based testing application that is designed to improve consistency across an organization, measuring how well and how consistently staff applies InterQual Criteria.

## InterQual® Content Customization Tool

Author and edit custom content so you can more closely match your medical and business policies and to create a single workflow for all of your utilization management content.

## **InterQual® Mobile**

Designed for Android and iOS (Apple®) mobile devices, this digital version of the InterQual books offers the same leading criteria with faster, anywhere mobile access. Included at no additional cost with an InterQual license.

## **CareEnhance® Review Manager Enterprise**

This browser-based, interactive utilization management workflow software puts the power of InterQual at reviewers' fingertips to support reduced variation in clinical decision making. Review Manager helps automate the care review process, aggregate reporting and electronically share medical necessity reviews.

## **InterQual Connect™**

InterQual Connect is the only solution that automates the medical review and enables automated authorization within the context of existing workflows. It is designed to work with the platforms and capabilities you already have so that you gain the functionality you need without sacrificing or duplicating previous investments. The result? A unified workflow that helps lower administrative costs when determining medical necessity and authorizing care. No time is wasted installing new software, jumping from one application to another, conducting manual medical reviews, repeating medical review efforts or following up on manually passed information.

## **Clear Coverage™**

A cloud-based application and platform that automates authorization and coverage decisions in real-time. Clear Coverage incorporates InterQual Criteria and a health plan's business rules into its fully automated, interactive workflow to help streamline medical review. It is the only auto-authorization product that includes network steerage and benefit/eligibility verification. Enables provider transparency and improves collaboration between payers and providers.

## **McKesson Diagnostics Exchange™**

This test identification and policy management solution connects payers, laboratories, and physicians to drive appropriate molecular diagnostics coverage and reimbursement. Tests are precisely identified using McKesson Z-Code™ Identifiers and test information, including evidence, is accessible through an open, online catalog.

# Decision Management Services

## Implementation: Get Started

Benefit from expert knowledge and guidance at the very start. We provide a dedicated team of technical consultants, clinical consultants, and project managers to help you get started with our software solutions. Implementation services are provided for CareEnhance Review Manager, InterQual Connect and Clear Coverage.

## Education: Grow Team Proficiency

The best clinical decisions are made by confident and knowledgeable staff. Our clinical educational consultants can help meet your staff development needs with rigorous and effective InterQual Criteria training options. All of our clinical educational consultants are qualified registered nurses with experience in case management and utilization management. Your team will access all programs via InterQual Learning Source, our web-based education platform.

- **InterQual Learning Basics:** Flexible and on-demand introductory training on InterQual Criteria and our software solutions. These entry-level modules help you get started with our products and prepare new users for implementation and education programs.
- **End-User Education:** Introductory and annual live training sessions with a clinical educational consultant who assesses your team's strengths and needs to improve their usage and outcomes with InterQual.
- **Physician Education:** Training on InterQual designed by and for physicians with a provider focus on common questions and case studies.
- **InterQual Expert Resource Program:** An advanced-level program that creates internal client experts and gives clinical participants the knowledge and resources they need to more fully leverage your InterQual products.
- **InterQual Certified Instructor Program:** A "train-the-trainer" program that provides qualified clinical instructor candidates with the knowledge and materials to train others within your organization.

## Consulting: Improve Outcomes

Our professional consulting services can help you get the greatest value from your InterQual Criteria and Decision Management technology. Through analysis and direct observation, we can help you optimize product performance, improve business processes, identify strategic opportunities, and expand or develop new medical management programs and capabilities.

# RelayHealth Financial Solutions: For Providers

RelayHealth Financial solutions enable providers to automate the revenue cycle end-to-end, reduce cost to collect, and accelerate accurate payment. Analytics offer data insights to help providers identify opportunities for improvement within their revenue cycle and chart a successful path through changing payment models. RelayHealth Financial solutions also improve communication with patients so you can offer a payment experience that matches your clinical excellence.

## **RelayClearance™**

A patient access solution that provides financial visibility so the entire patient visit and reimbursement cycle is more efficient. RelayClearance helps manage critical patient access activities as early in the revenue cycle as possible, enhancing the provider's ability to collect payment at or before the time of service. It also helps improve data accuracy at patient registration and manages the pre-authorization process which reduces claims denials and rework.

## **RelayAccount™**

When patients are clear about what they owe, when it's due, and they are also given a simple way to pay, cash flow increases and A/R days go down. This online patient payment and account management solution truly brings clarity.

## **RelayAssurance™**

This solution helps speed reimbursement and reduce costs by applying comprehensive business rules to claims, increasing first pass claim acceptance rates, and pairing automation and advanced workflow with meaningful reporting.

## **RelayAnalytics™ Acuity**

This business intelligence tool offers revenue cycle leaders strategic insight into the large volume of data that their hospital generate to inform decisions made in key areas impacting the revenue cycle.

## **RelayAnalytics™ Pulse**

This solution provides near real-time visibility into your own hospital's performance and provides context for metrics by comparing to similar hospitals across the country. Identification of payment obstacles and root cause analysis of issues can be performed quickly to guide business process improvements and help positively impact revenue cycle results.

## **RelayLearn™**

A web-based knowledge portal that provides online education offerings for RelayHealth Financial's Solutions 24/7.

## **RelayClearance™ Professional Services**

RelayClearance Professional Services helps your organization further integrate our solutions to optimize daily workflow. We'll work with you and your staff to determine areas that need improvement, and then we'll conduct research and analysis to determine possible solutions.

## **RelayAssurance™ Professional Services**

RelayAssurance Professional Services helps you integrate RelayAssurance into your daily workflow processes and assists in the automation of as many manual processes as possible to increase staff productivity and process efficiency. Leveraging your own data, we can help you understand how to use RelayAssurance to maximize your revenue cycle experience.

# Annotations

- <sup>1</sup> "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," Secretary Sylvia Burwell, January 26, 2015
- <sup>2</sup> "The 2014 State of Value-Based Reimbursement," McKesson Health Solutions
- <sup>3</sup> Ibid.
- <sup>4</sup> Ibid.
- <sup>5</sup> Ibid.
- <sup>6</sup> Ibid.
- <sup>7</sup> "20 major health systems, payers pledge to convert 75% of business to value-based arrangements by 2020," Emily Rappleye, Becker's Hospital Review, January, 2015
- <sup>8</sup> "Where health care is now on march to value-based pay," Melanie Evans & Bob Herman, Modern Healthcare, January, 2015
- <sup>9</sup> Ibid.
- <sup>10</sup> "Hospital revenue cycle operations: Opportunities created by ACA," Bayley, McKinsey, et al., May 2013
- <sup>11</sup> NHE Projections 2013-2023, Office of the Actuary in the Centers for Medicare & Medicaid Services, December 2012
- <sup>12</sup> "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," The National Academies of Science, Engineering & Medicine, September 2012
- <sup>13</sup> American Medical Association study of 2400 physicians' prior authorization practices, November 2010
- <sup>14</sup> Bayley, McKinsey, et al., see footnote 10
- <sup>15</sup> "Waste in the U.S. Health Care System Pegged at \$700 Billion," Thompson Reuters, October 2014
- <sup>16</sup> "The California Department of Corrections & Rehabilitation Reins in Costs and Ensures Appropriate Care with Decision Support Criteria & Software," McKesson Case Study, August 2013
- <sup>17</sup> "Palmetto GBA cut its MDx spending in half with innovative approach" McKesson Case Study, January 2014
- <sup>18</sup> Based on client results, McKesson 2013
- <sup>19</sup> Based on client results, McKesson 2013
- <sup>20</sup> "Iowa Medicaid Enterprise and IFMC Rein in Imaging Costs with Clear Coverage and InterQual Criteria" McKesson Case Study, August 2012
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- <sup>24</sup> PwC Touchstone Survey, 2013
- <sup>25</sup> American Medical Association National Health Insurer Report Card, Towers Watson/National Business Group Health Employer Survey on Purchasing Value in Health Care, 2013
- <sup>26</sup> "HHS Says 16.4 Million People Have Gained Insurance Under Health Law," KHN Morning Briefing, March 2015
- <sup>27</sup> Ibid.
- <sup>28</sup> PwC's 2014 Health & Well-being Touchstone Survey, June 2014
- <sup>29</sup> Stateside Associates and MHS internal analysis for the period of January 1,2015 through July 27, 2015
- <sup>30</sup> "New AMA Study: Patients Responsible for Nearly One-quarter of the Medical Bill," American Medical Association, June 2013
- <sup>31</sup> "Nearly half of exchange products offer narrow networks," Modern Healthcare, June 2014
- <sup>32</sup> "Transparency & Disclosure of Health Costs & Provider Payments: State Actions," National Conference of State Legislatures, January 2015
- <sup>33</sup> "Metrics for Transformation-Transparency," Health Care Incentives Improvement Institute, 2015
- <sup>34</sup> "California Regulators Find Many Problems with the Provider Directories That Health Insurers Make Available to Consumers," Dark Daily, March 2015
- <sup>35</sup> "Improving Patient Payment Process" McKesson Case Study, June 2013
- <sup>36</sup> "Better Upfront Estimates Help Improve Patient Financial Experience, Increase Point-of-Service Collections," McKesson Case Study, March 2013
- <sup>37</sup> "Electronic Registration Improves Wait Times, Billing Accuracy," McKesson Case Study, June 2013
- <sup>38</sup> "Waste in the US Health Care System Pegged at \$700 Billion in Report from Thomson Reuters," FierceHealthcare IT, October 2009
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- <sup>42</sup> Statistical Brief # 172, Hines et al., Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project, April 2014
- <sup>43</sup> Based on aggregated client results, McKesson, 2012
- <sup>44</sup> Based on client result, McKesson, 2012
- <sup>45</sup> McKesson case study, see endnote 15

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